



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CASA VIEW CHIROPRACTIC CLINIC
10622 SHILOH ROAD
DALLAS, TX 75228

Respondent Name

SENTRY INSURANCE A MUTUAL CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-3074-01

MFDR Date Received

JUNE 08, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Provider request that the Division review the supporting documentation enclosed in order to determinate appropriate reimbursement per 28 TAC §134.204. Sentry Insurance Company needs to submit payment in a timely matter for the amount of \$800."

Amount in Dispute: \$800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No response received from the carrier

Response Submitted by: N/A

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 01, 2012	CPT Code 99456-WP	\$800.00	\$ 0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, 37 Texas Register 3833, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
- 28 Texas Administrative Code §134.204 sets out the fee guideline for Workers' Compensation Specific Services on or after March 1, 2008.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - No Explanation of benefits provided

Issues

- Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.204?

2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 (i) The following shall apply to Designated Doctor Examinations.
(1) Designated Doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041 and 408.151 and Division rules, and shall be billed and reimbursed as follows: (A) Impairment caused by the compensable injury shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor;
2. Requestor failed to meet the requirements, no additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

Date

June 21, 2013

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.